# *California Association of Addiction Recovery Resources*

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September 7, 2011

Mr. Michael Cunningham, Acting Director
Mr. Dave Nielsen, Deputy Director
California Department of Alcohol and Drug Programs
1700 K Street
Sacramento, California 95814

RE: Commentary on Realignment Proposal Eliminating the ADP via Merger into another State Department

Dear Director Cunningham and Deputy Director Nielsen;

The California Association of Addiction Recovery Resources (hereinafter CAARR) greatly appreciates the opportunities you have provided for the many public discussions ADP has organized, and for your invitation to submit written commentary, regarding the proposal to eliminate ADP.

CAARR, our members' treatment programs and their counselors, along with many other stakeholder groups, have consistently participated in virtually every program initiative ADP has been involved with for almost 33 years, by offering counsel, recommendations, cooperation, and an ongoing dialogue intended to best serve the needs of ALL of people in the AOD community. We believe the government, providers, counselors, counties, and consumers have an equal stake in creating a continuum of care and that collectively, we have achieved it. One major result of the private / public partnership that has existed in California for almost 33 years is a series of statewide programs administered by ADP that in many ways comprise the best in the nation. ADP effectively regulates the programs in ways that have been largely successful, despite being generally underfunded.

As you know, CAARR is highly involved in discussions over the functional merger of "drug" Medi-Cal into DHCS. However, **this commentary** discusses **ONLY** the proposed realignment / elimination / merger of the entire Department of Alcohol and Drug Programs into another state department.

Sincerely,

Susan B. Blacksher, MSW, MAC
Executive Director

# *Preface*

Governor Brown's Administration indicated both in his January budget and the May Revision that he intends to propose elimination of ADP and DMH as part of "Realignment - Phase 2" in the 2012-13 budget year. Documentation provided in January includes the following statement regarding realignment in general:

> "Since Proposition 13, there has been a steady back-and-forth of revenue allocations and program responsibilities between the state and counties, blurring responsibility and driving up program costs ..... The long-term goal is not to reduce services, but rather to provide services ***more efficiently and at less cost***." (*emphasis added*)
> Source: http://www.ebudget.ca.gov/pdf/BudgetSummary/Realignment.pdf

In these few simple words, the entire rationale for the Governor's realignment proposal is made plainly and clearly. Realignment is intended to make programs both more efficient and less expensive.

## Evidence Regarding Measurements of Efficiency Improvements of Previous "Realignment" Proposals

Dozens of commissions established to recommend ways to improve government efficiency have issued series' of recommendations, in California and throughout the states' and federal government programs. Unfortunately, actual, after-the-fact analyses of streamlining / efficiency efforts seem exceedingly rare. Most likely this is because while many states have eagerly spent tax dollars to institute working groups or 'commissions' to study ways to effectively 'realign' programs, apparently very few are eager to allocate additional resources to assess 'realignment' efficiency and cost savings impacts *post hoc*. The only exception we have found thus far is summarized in a February, 2011 article by the Executive Director of Governing Magazine, which states:

> "According to a study by the University of Texas' Lyndon B. Johnson (LBJ) School of Public Affairs, the TRP (Texas Public Review Commission) had some positive -- although clearly mixed -- results. Auditors identified nearly 975 ways the state could save $5 billion. Those ideas included consolidating 12 human services departments into one and expanding experiments with privatized prisons. In the end, the state enacted about two-thirds of the TPR's recommendations, adding up to $4.2 billion, **$2 billion of which came from tax and fee increases**." (*emphasis added*)
> *http://www.governing.com/topics/mgmt/State-Efficiency-Commissions-Effective.html*

CAARR wishes to emphasize that of more than 600 enacted recommendations in Texas, including consolidating 12 human services departments and privatizing prisons, over multiple years, the state of Texas realized pure cost savings of approximately $2

billion distributed among that enormous variety of departmental and program changes. Nothing is mentioned (at least in the summary) about service delivery or efficiency. Nothing is mentioned about where the cost savings came from.

In May, 2011, the Legislative Analyst's Office recommended realignment principles to the Legislature regarding the best ways to approach transforming government. LAO effectively summarizes much of the 'guidance-for-realigning' literature:

**Final Words of Caution**

- **As With Any Complex Legislation, the Details Really Matter**
- **Achieving General Consensus Is Critical**
- Close consultation with counties is essential
- **Realignment Plans, Once Adopted, Are Not Easily Changed**
- Mandate issues, practical constraints, make mid-course corrections difficult.
- More pressure to get it right the first time.

*http://www.lao.ca.gov/handouts/state_admin/2011/Gov_Realignment_2_14_11.pdf*

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## *Essentials*

CAARR's position on eliminating ADP, as of now, is to oppose the proposal. This is not a position we adopted lightly. This is not an unyielding position. But we do not believe that any substantive case for merger / elimination / realignment has yet been made, or that the rationale for why it ought to be done has been thoroughly explained.

The Governor stated that his proposals are aimed at providing services more efficiently and at less cost. CAARR certainly agrees with those two goals. We believe, however, that the ADP elimination proposal should not proceed until the State has developed clear documentation, along with a supporting socioeconomic cost-benefit analysis, demonstrating real cost savings, and management efficiencies, and program improvements *viz.* the existing situation and *viz.* other alternative scenarios. Evidence produced by analytical techniques such as academically defensible socioeconomic cost-benefit analysis seems a proper prerequisite to moving forward. Eliminating ADP before conducting a meaningful and valid analysis would be short-sighted, could actually end up raising costs, weakening programs and thereby pose a potentially devastating threat to the health and well-being of millions of Californians.

In addition to, and very distinct from our concerns about efficiencies, cost savings and long term service improvements, CAARR believes that there is tremendous and inherent value in maintaining ADP as a single, stand-alone entity with full Departmental status, specializing in and dedicated solely to the Alcohol and Other Drug (AOD) field. The AOD field is quite small compared to most other Departments'. ADP is 'budget dust' in the current lingo. So it deeply concerns us that merging ADP's functions into a mega-department will leave the importance of ADP's mission lost

among relative giants, receiving minimal attention at the Director level, and susceptible to even further subordination during future budget cycles. The AOD field is much too important to receive 'also-ran' consideration. The facts speak for themselves:

- ADP and the treatment field in California had over 260,000 unique treatment and prevention contacts with people during 2008-09.
- Analyses documented in the Little Hoover's 2003 report of the socioeconomic costs of alcohol and drug abuse put the figure (nationally) at between $200 billion and $400 billion each year.
  (http://www.adp.ca.gov/SACPA/pdf/LittleHooverFinalReport_Mar2003.pdf )
- As much as 41% of all auto wrecks are attributed to alcohol, killing approximately 1370 in California in 2008. As many as 80% of all people in state and county correctional systems have abused alcohol or other drugs.
- An estimated 10% of all people in California who need AOD treatment actually receive it. 90% do not.

These facts address the severe consequences of AOD addictions. CAARR believes that diluting the important work ADP performs by submerging its core functions in a much bigger bureaucracy will likely multiply the already severe consequences of addiction. CAARR believes that instead of submerging it, that ADP should be further strengthened as a stand-alone Department. Every dollar invested in treatment avoids seven dollars in other state costs (also per the 2003 Little Hoover Commission report cited above).

CAARR intends to remain a close partner with the State as a merger / elimination plan is developed over the coming months. We are very pleased to be in the midst of public discussions that have taken place to date. We are pleased to respond to the set of public questions that ADP put to all the stakeholders. We are eager to assist in making the merger, if there is to be one, as smooth as possible and to help make it work for all our communities.

But again, lacking a clear and empirically defensible delineation of cost savings and efficiencies to be gained via eliminating ADP, we will likely continue believing that the risks of eliminating the Department far outweigh the presumed benefits, both in terms of tax dollars and in terms of human lives.

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# Administration-Issued Questions

1. ***What opportunities (Alternatively – what benefits to counties, providers or clients) do you see as a result of this transition?***

There is an opportunity to keep AOD treatment providers completely separate from purely "Mental Health" care providers. A recent contribution to Addiction Professional magazine by Robert Mooney, M.D., entitled "Busting the Myths about Dual-Diagnosis Disorders" is among a number of recent pieces questioning the wisdom of the 'dual diagnosis"/ licensed professional primary involvement in AOD treatment generating a great deal of discussion today:

> "The DSM-IV-TR (the diagnostic manual for mental disorders published by the American Psychiatric Association) advises that diagnoses of primary psychiatric disorders not be made in the absence of sobriety (of duration sufficient to allow for any substance-induced symptoms to dissipate) .... With denial as a predominate characteristic of those addicted to alcohol or drugs, medical and psychological histories presented to healthcare providers are often inaccurate. This pattern can lend itself to misdiagnosis."

There is also an opportunity to examine parts of the Health and Safety Code, as part of transition planning but which could be a stand-alone effort:

- to improve county-to-provider interaction by mandating county planning commissions;
- to make county budgeting of state and federal AOD dollars much more transparent (currently it is incredibly opaque) by reinstituting advisory committees with status as full partners;
- to require counties to obey the statute that requires services to be delivered by community providers unless there are no providers available to carry out specific functions by imposing penalties for noncompliance.

As of now, CAARR sees no other opportunities or benefits to providers or clients as a result of merely transferring all remaining ADP functions to another state Department. All current state personnel costs will just be transferred. A very similar amount of office space will still be required. All office equipment, outside contracts, maintenance costs etc. will continue to be spent. If actual benefits can be accurately described and demonstrated prior this 'transition', we will be glad to provide further commentary on it.

2. ***What do you believe will be the greatest challenge created by these changes (For counties, providers, clients)? What are your recommendations to address this challenge?***

The biggest challenge is clearly for future AOD clients. Their health and well-being is at serious risk, because eliminating ADP will necessarily result in a diminution of prevention and treatment, as the sense of urgency, importance and voice of AOD necessarily deteriorates while the Department's current status is downgraded. If ADP

is eliminated, our system of specialized counselors and programs could easily be eliminated. This is because if AOD is put into a MUCH bigger bureaucracy, clients will be lost in a system dominated by physicians, hospitals, and primary care clinics. What AOD providers do for clients is not duplicable in a medical setting or a mental health care setting.

Multiple challenges will present to providers who are likely to see their programs get buried within a very large state Department with multiple agendas other than the AOD field. Publicly funded programs may become even more dependent on the whims of 58 different county program administrators, who themselves are subject to the political decision-making determined by 58 disparate County Boards of Supervisors. Budget pressures at the county level have already been responsible for what may well be the misallocation of earmarked AOD treatment dollars (or at the very best, a focus on redefining roles of county staff within the budget-making processes to allow treatment funds to be allocated to preserving those bureaucracies).

Another enormous challenge arises, very coincidentally in terms of timing, because of PPACA, national health care reform. CAARR believes California has a perhaps unique opportunity among states to form a program in which independent, community-based organizations that provide the bulk of AOD prevention and treatment services are fully equal partners in the payment / reimbursement reforms that will unfold in 2013. Without a strong ADP holding an equal seat at the table at the HHS Agency planning and decision-making tables, the AOD field and clients are much more apt to be left on the sidelines.

3. ***What are the most important functions/activities/programs to be performed (or retained?) at the state level? (Are there any new ones?)***

**All current core state functions must be retained at the state level.**

Local governments are not prepared or equipped to license and certify treatment programs or to actually regulate how counties themselves decide how state and federal dollars are spent within their own counties. Ample evidence currently exists that Counties are and have been misallocating state and federally-earmarked AOD treatment dollars, especially in the last several years. It is abundantly clear to virtually every publicly funded community-based program in California that far too much money is going somewhere else instead of getting to clients in community-based treatment where it is intended to be.

ADP is bound by law to allocate almost all state and federal funds to counties. As is reiterated in CAARR's response to Question #4, publicly funded programs are already almost exclusively dependent on the whims of 58 different county program administrators. Individual counties effectively already handle all allocations within counties. But these county administrators are completely subject to highly political decision-making processes involved in county budgeting decisions, which are determined separately and essentially at the sole discretion of 58 very disparate

County Boards of Supervisors. Virtually all stakeholders are already aware that the current allocation system within counties has very severe shortcomings.

CAARR suggests ADP undertake an aggressive audit of how counties have actually spent earmarked state and federal AOD program funds over the last 2-3 years (regardless of whether its audit function remains at the state level during the presumed transition). In the future, regardless of the name of the state agency undertaking ADP's current audit function, those audits really have to been made much more rigorous and be made much more public.

4. ***What are the most important functions/activities/programs to be performed at (or transferred to) the county level? (Are there any new ones?)***

NONE. The counties should not take over any of the core functions listed on the recent ADP stakeholder meetings handout that's headlined "FUNCTIONS RETAINED AT STATE LEVEL (Proposed), August 2011".

There are enormous conflicts of interest for counties in areas like data reporting and analysis, Statewide Needs Assessments, provision of technical assistance, and SAMHSA Discretionary grants.

The need for uniform statewide standards for program licensing, program certification, and counselor credentialing should be abundantly clear, but CAARR finds cause to re-iterate the necessity for statewide standards carried out at the State level.

If ADP is eliminated, CAARR believes all its core functions must remain <u>together,</u> in a single Office or Division of Alcohol and Drug Programs, within the Department of Public Health. CAARR is absolutely opposed to <u>any administrative linkage of ADP and DMH</u> in a re-packaged scenario. They are completely different fields, AOD is smaller, and would end up submerged under Mental Health administrators and their stakeholders. On a related note, CAARR would also be opposed to nomenclature reflecting terms like "Behavioral Health" in front of any Office or Division in which ADP's current core functions are carried out.

DHCS, as some stakeholders prefer, is absolutely the **wrong** location to place ADP's core functions. DHCS is a Medicaid / Medi-Cal agency ONLY. DHCS is only a few years old, and was created specifically to separate Medi-Cal functions from everything else in the bygone Department of Health Services. There is zero expertise at DHCS in facility licensing, for example, which is one of several key issues that must remain at the same level. AOD addiction is a chronic disease, like HIV/AIDS, diabetes, etc. DPH already regulates single-diagnosis programs, and therefore is the only logical Department to consider.

5. ***What specific strategies should the Department of Alcohol and Drug Programs undertake to engage racially, ethnically, linguistically, and***

***culturally diverse clients, family members, and community stakeholders? (and to ensure their concerns in this process are identified)***

Outreach to specific communities (e.g. Native Americans, Latinos, Women, LGBT, African Americans, the Disabled, Asian Americans etc. etc. etc.) is more than critical. It is absolutely imperative since some of these underserved communities are disproportionately impacted by AOD addiction issues. Many community-based organizations --- including CAARR and other COs --- exist all over the state to help the Department make this happen.

There is no mystery to finding organizations – mostly not for profit and mostly community-based – that represent virtually every underserved community despite the diversity which enriches California in the 21st century. If there are problems in devising these kinds of 'engagements', then CAARR would be delighted to assist in identifying and reaching out to these communities and organizations.

6. ***How can we best continue to involve stakeholders on an ongoing basis after the <u>October</u> Stakeholder Summary has been released?***

The Governor won't release an official proposal until January. Why is there an October deadline? All stakeholders should be involved all the way through the planning phases. The Legislature has not set a requirement for an "October Summary". This is too important to rush through, and October means rushing through it.

ADP and HHS should continue prioritizing stakeholder input and outreach to additional layers of stakeholders. Discussions should be opened to many more types of questions because the current list of questions is entirely and much too narrowly focused. Additional public meetings can't be based purely on the assumption that ADP will be eliminated. Instead, a much more open dialogue needs to happen as to WHETHER the elimination is wise, justifiable, and beneficial to all Californians. This kind of discussion has been almost completely absent so far. There is still plenty of time to have that discussion. A final 'elimination' proposal has until May, 2012 to be developed. CAARR will be pleased and eager to continue participating.